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‘Male’ficence or ‘Miss’understandings? : Exploring the Relationship Between Gender, Young Healthcare Professionals, Social Media, and Professionalism

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Abstract

This book chapter considers the role that social media, especially Facebook and Twitter, can play in raising awareness of the gender inequality that defines the organisation of healthcare and the healthcare professions. The discourse of healthcare professionalism assumes that, in conjunction with the feminisation of the profession, healthcare practitioners are best considered as gender-neutral actors who work in predominately inclusive workplaces. This chapter uses a digital feminist approach to challenge this assumption and identifies two cases from social media, the Dalhousie University Facebook incident and the #ILookLikeASurgeon hashtag movement, to argue that gender discrimination is an active feature of the healthcare profession, for students and early-career professionals alike. It will be contended that the expressive and participatory nature of social media can be recognised as playing a positive role in raising the issue of gender inequality within and beyond the profession. This book chapter will also include some recommendations for how to transform this gender awareness into sustainable change.

Introduction

Historically healthcare has been conceptualised as masculinist (Adams 2005, 2010), with women being actively prohibited from entering some fields, like medicine and dentistry, until the early twentieth century. Women who wanted a career in healthcare at that time were funnelled into specific roles and professions, such as nursing, which came with lower status (Adams 2010). Despite this 'dominant gender order' (Lazar 2005, 2007; De Simone and Scano 2017) (Lazar 2005, 2007, cited in De Simone and Scano 2017: 1), the past five decades have seen an increase in the number of women entering healthcare professions, including those that were considered the traditional preserve of men (Hedden, Barer, Cardiff, McGrail, Law, and Bourgeault 2014). Currently women make up 42 per cent of the world's workforce, and in healthcare they account for 75 per cent of the workforce (Human Resources for Health: Global Resource Center 2008). Forty per cent of practising physicians in the West are female (Arrizabalaga, Abellana, Viñas, Merino, and Ascaso 2014: 363). (OCED 2009, cited in Arrizabalaga, Abellana, Viñas, Merino, and Ascaso 2014: 363). Thirty-two per cent of all graduate physicians worldwide are female (Hedden et al. 2014), and 58 per cent of medical school enrollees in Canada are female (Hedden et al. 2014:1) 1/12). In 2013, 63 per cent of dental students and 49 per cent of registered dentists in the EU/EEA were female (Council of European Dentists 2015: 33, 39). These workplace statistics indicate that healthcare has undergone a process of feminisation (Adams 2005; Brocklehurst and Tickle 2011; Gross and Schäfer 2011), namely, a numerical increase of women in healthcare, including medicine (Heru 2005; Riska 2005, 2011) and dentistry (Adams 2005; Neville 2017a; Waylen, Benyan, Barnes, and Neville 2017).

For some, the changing gender composition of the healthcare professions signifies that hegemony has been overturned and gender equality has been achieved. For the current Millennial workforce and the incoming Generation Z professionals, gender equality in the workplace is recognised as a 'vital and non-negotiable right'(Ernst & Young 2016: 9). However, Reskin and Roos (1990) remind us that feminisation can be a complicated process and that the increased numbers of women do not automatically ensure the successful integration of women into health professions. The literature identifies structural and cultural barriers encountered by women who want to progress in a healthcare career(Geroge 2007; Newman 2014; Newman, Ng, Pacqué-Margolis, and Frymus 2016) (George 2007; Newman 2014; Standing 2000, cited in Newman, Ng, Pacqué-Margolis, and Frymus 2016: 3). It has long been recognised that the organisational structure of healthcare, like other organisations, presents structural difficulties for women juggling family and a career (Langer, Meleis, Knaul, Atun, Aran, Arreloa-Orneles et al. 2015: 1186). For instance, more men are practicing medicine across the WHO region than women, with the exceptions of the UK, the Nordic region, and some Eastern European countries. Yet, there are more women than men in medical school (George 2007; Langer, Meleis, A, Knaul, FM, Atun, R, Aran, M, Arreola-Ornelas, et al. 2015). For instance, more women than men are currently in medical school, yet more men than women are practising medicine across the WHO region (George 2007, cited in Langer et al. 2015: 1185), with the exceptions of the UK, the Nordic region, and some Eastern European countries. Female dentists are more likely to work part-time and take career breaks than their male counterparts (Ayers, Thompson, Rich, and Newton 2008: 347). The most popular reason women take a career break is to care for children, whereas men typically use career breaks to find a new job, to pursue study, or out of personal choice (Ayers et al. 2008: 348). Most women take on postgraduate training before children (60.7 per cent), unlike men (34.3 per cent) (Ayers et al. 2008) Most women take on postgraduate

training before children (60%) compared with men (34%) (Ayers et al. 2008). Moreover, a woman's choice of speciality is often determined by location and proximity to family (Saeed et al 2008; McKay and Quiñonez 2012). (Saeed et al. 2008 cited in McKay and Quiñonez 2012: 4). These gender differences have led some to suggest that feminization poses challenges to the healthcare workforce in the coming decades (eg Brocklehurst and Tickle 2011).

Research has also identified a sex pay gap and sex segregation within healthcare. There is a lack of women leaders in global health (Talib, Burke, and Barry 2017), in senior posts or managerial positions (Hamel et al 2008; Arrizabalaga, Abellana, Viñas, Merino, and Ascaso 2014; Human Resources for Health: Global Resource Center 2008) (Hamel et al. 2008; Mayer et al. 2008, cited in Arrizabalaga et al. 2014: 363; HRH Resource Center 2008). Furthermore, a recent headcount UK survey reported that women are over-represented in dental public health (54%), paediatric dentistry (59%), and special care dentistry (85%), whereas a greater proportion of men have careers in oral and maxillofacial surgery (73 %), orthodontics (68%), periodontics (73%), and restorative dentistry (72%) (Dental Schools Council 2018).

As restrictive as these structural constraints are, more damning are the cultural barriers that female healthcare professionals encounter. It is commonly assumed that the increase of women in healthcare will change the profession's values and practices (Riska 2001; Adams 2010). For instance, US research claims that the rigid masculine norms of dentistry have become more accepting of women entering the profession (Rosenberg, Cucchiara and Helpin 1998). (Rosenberg, Cucchiara, and Helpin 1998, cited in Schéle, Hedman, and Hammarström 2011: 2). However, in medicine, it has been well documented that female doctors adopt 'male professional norms' for social acceptance. This change also creates issues regarding professional communications (e.g. Schéle, Hedman, and

Hammarström 2011:2) (eg, Cassell 1997; Davies 2001; Eriksson 2003, cited in Schéle et al. 2011: 2). Such observations reveal the gender stereotypes that female healthcare professionals encounter which actively limit their everyday working lives. Gender stereotyping has also been found to influence choice of college course and career (Newman et al. 2016: 4), and several surveys attest to the continued prevalence of sexual harassment in medicine, both during training and when in practice (Mathews and Bismark 2015: 189; Newman et al. 2016: 4).

Despite the ongoing feminisation of healthcare (Dacre 2011; De Simone and Scano 2017) (Dacre 2011; Mapp 2009, cited in De Simone and Scano 2017: 1) a 'strong gender asymmetry' persists (Davidson and Burke 2016; De Simone and Scaro 2017) (Davidson and Burke 2016, cited in De Simone and Scaro 2017: 1), shaping and modifying women's professional experiences. Such everyday work realities are unacceptable, but especially to the current Millennial workforce, who have high expectations and are keen to challenge what they consider to be outdated workplace norms. These occupational realities are also unsettling for the incoming Generation Z, who value and champion diversity and inclusion in all aspects of their lives (Ernst & Young 2016: 5, 11). Despite the progressive work style and expectations of today's young professionals, it is interesting to observe how entrenched and stubbornly persistent gender discrimination is in healthcare. The lacklustre institutional response to problems may be, in part, attributed to the rhetoric of gender blindness that permeates the discourse of professional education and professionalism more generally. Numerous authors remind us that our construction of professionalism is rooted in androcentric ideals, which are also middle class, White, and Victorian (Adams 2010; Schleef 2010). Furthermore, the aim of professional education is the production of a homogenous practitioner (Larson 1977). One way to ensure this is for professional education to dismiss

and actively discourage the understanding that social variables such as gender, age, class, and ethnicity have a bearing on professional practice.

Though the rhetoric of feminisation pronounces that the increased intake of women into medicine and dentistry is unproblematic, it obscures the fact that these professions retain a patriarchal value system that needs to be addressed and tackled. I object to the way the discourse of healthcare professionalism dismisses and silences women's experiences of gender stereotyping, discrimination, and inequality in healthcare. Inspired by the recent hashtag movements and their effect of raising awareness of everyday gender inequalities, I contend that social media can be considered a means of raising awareness of the insidious sexism in healthcare and the challenges that women face as they try to progress their careers within a masculinist work culture (see De Simone and Scano 2017). In this way, we may be able to identify attempts by young professionals to 'crack the gender equality code' that they encounter in their workplaces (Ernst & Young 2016: 11). Two recent case studies will be introduced and discussed, and a feminist analysis will be undertaken to uncover the persistence of misogyny, sexism, and gender discrimination in healthcare in the twenty-first century. In keeping with the ideals of feminist analysis, policy and activism outcomes will also be presented for consideration.

Digital Feminism, Social Media, and Healthcare Professionalism: A Note on Method

The aim of this book chapter is to explore women's experiences of everyday sexism in the healthcare professions and to present a feminist analysis of two recent social media events to illuminate the underlying tensions in the profession for women—misogyny, sexism, and gender discrimination. A feminist approach has been taken because the values of feminism mirror the values of this research and its researcher: a desire to challenge the status quo and

question the gender hierarchies, male privilege, and power imbalances inherent in healthcare (Kangere, Kemitare, and Michau 2017: 901).

Feminism can be defined as ‘a movement to end sexism, sexist exploitation, and oppression’ (hooks 1984: 26) (hooks 1985). Feminism allows us to investigate how gender inequalities are implicated in the relationships of women and men, but also traces where these inequalities emanate from at a structural/macro-systems level and how they impact on the lifeworld/micro-systems micro level (Locke, Lawthom, and Lyons 2018: 5) of women. Increasingly we find feminism turning its attention to digital spaces, recognising such spaces as settings where ‘issues of privilege, difference and access’ (Baer 2016: 18) can be found and studied. ‘Digital feminism’ (Baer 2016: 18) recognises that digital spaces can be positive and negative for feminist conversations and debates (Turley and Fisher 2018: 128). This ambiguity reflects wider distinctions in digital research and debates about whether digital media can be considered inherently democratic, transcending social categories and distinctions (Duffy 2015:710) (eg, Bruns 2008; Shirky 2008, cited in Duffy 2015: 710), or if in fact it reproduces and re-problematises existing gender relations (Duffy 2015: 710). There is also recognition that cyberspace is gendered (Locke et al. 2018: 4) and that a ‘matrix of sexism’(Stubbs-Richardson, Rader and Cosby 2018: 94) (Stubbs-Richardson et al. 2018, quoted in Locke et al. 2018: 4) defines the online world. For instance, a ‘gender digital gap’ exists globally, with the proportion of women using the internet worldwide 12 per cent lower than the proportion of men using this technology (International Telecommunications Union 2017). While there are slightly more women than men using the internet in The Americas (67% women, 65% men), in Europe the gender digital gap favours men (83% men, 76% women) (Statista 2018a) (Statista.com 2018a). Furthermore, a recent US study of 4248 adults found that 41% of respondents had been subjected to online harassment, such as name-calling. A further 18% experienced more severe forms of online harassment, including

receiving physical threats, sexual harassment, or stalking (Duggan 2017). While men experienced more online harassment than women, for women, the focus of the harassment was sexual in nature (Duggan 2017).

The gendered nature of the online world is also evidenced in social media. Social media, by definition, are online technologies that provide the ability for community building and interaction, allowing people to interface, share, create and consume online content (boyd and Ellison 2007; Locke et al 2018:3). 'online technologies that provide the ability for community building and interaction (boyd and Ellison 2007), allowing people to interface, share, create and consume online content' (Lyons et al. 2017 cited in Locke et al. 2018: 3). Social media achieves this impact because of its discreet set of characteristics, namely, that it is inherently 'social, participatory, locative, algorithmic, interactive, affective and entangled with bodies' (Locke et al 2018:3) (Carah 2017 cited in Locke et al. 2018: 3). Since the 2010s there has been an increase in the use of social networking sites (SNS) and blogs to raise awareness of issues relating to hegemony and sexism (Baer 2016). Understandably, there has been recent growth in feminist social media research. Feminist approaches to social media are multiple and evolving. Currently, we can categorise feminist social media research according to the following subject matters: investigations into the relationship between the social variables of actors and their online interactions (e.g, Banet-Weiser 2011); undertaking a feminist analysis of the values encoded in social media technologies and computer design (e.g. Bardzell 2010; Wajcman 2010); exploring the ways institutions and political decision making is shaped by social media practices(e.g. Papacharissi 2010; Taylor 2014), and researching 'the ways online interactions over particular social media platforms coincide with existing inequalities and hierarchies situated in specific communities' (Korn and Kneese 2015: 708).investigations into the relationship between the social variables of actors and their online interactions (eg, Banet-Wesier 2011; Hasinoff 2013; Schradie 2012; Senft 2010, cited

in Korn and Kneese 2015: 707); undertaking a feminist analysis of the values encoded in social media technologies and computer design (Bardzell 2010; Cassell 2002; Gillespie 2010; Wajcman 2010, cited in Korn and Kneese 2015: 707); exploring 'how institutional organizations and political actions both influence and are conditioned by social media practices' (boyd 2014; Juris, 2012; Papacharissi 2010; Taylor 2014, cited in Korn and Kneese 2015: 707), and researching 'the ways online interactions over particular social media platforms coincide with existing inequalities and hierarchies situated in specific communities' (Korn and Kneese 2015: 708).

This book chapter aligns itself with the latter subject matter and takes as its starting point the recognition that social media can be 'a promising tool for spreading feminist discourse' (Kangere et al. 2017: 899). Particularly effective in this area have been hashtag movements like #EverydaySexism and #GamerGate where Twitter hashtags were used as tools to combat misogyny in everyday life and in the gaming community, respectively (Bates ND; Korn and Kneese 2015:708). (Bates ND; Wofford 2014, cited in Korn and Kneese 2015: 708). Hashtag activism involves creating and using hashtags as 'a way of exposing the prejudice faced by people on a daily basis, while sharing and reacting to it, and provoking responses' (Turley and Fisher 2018: 128).A hashtag movement, 'responding using a hashtag in digital spaces is a way of exposing the prejudice faced by people on a daily basis, while sharing and reacting to it, and provoking responses' (Turley and Fisher 2018: 128). These online activities are taken to represent 'shouting back' against 'hegemony, misogyny and sexism' (Turley and Fisher 2018: 128). This 'hashtag feminism' has also been found to result in 'changed modes of communication, different kinds of conversations and new configurations of activism across the globe, both online and offline'(Baer 2016: 18).

I recognise the potential that 'digital platforms' have to articulate ideas about gender, healthcare, and sexism, and in so doing allow for new forms of protest or 'shouting back'

against gender hegemony. I will shortly present two case studies which I believe illustrate some of these ongoing tensions within healthcare professions. However, there are limitations to this research method. From a feminist perspective, it is important to remember that digital space is not a utopia for the feminist cause. By raising awareness about gender issues the resultant visibility can lead to an increase of 'misogynistic and sexist narratives' being communicated online, which in turn can be used to 'shame' women and uphold inequalities in the offline/real world (Turley and Fisher 2018: 129). As a result, the feminist online activist can be victimised or trolled through social media online (Turley and Fisher 2018: 129) or harassed and bullied Boynton 2012). (Boynton 2012, quoted in Turley and Fisher 2018: 129). Furthermore, it is important to match hashtag activism with offline activism to publicise the issue (Turley and Fisher 2018: 129); however, sometimes this is difficult to do.

At a more methodological level, there are also disadvantages with analysing social media 'stories'. In some cases, social media events can dilute or simplify complex issues on gender inequality to appeal to the majority. As a result, we should approach these case studies with some caution, as they cannot give comprehensive coverage to the issues at play, probably only highlighting one or two issues at a time (Kangere et al. 2017: 901). Another limitation of social media stories is the fact that they have an explosive timeline: quickly emerging onto the digital sphere, having their 15 minutes of fame or traction, and then disappearing again (Kangere et al. 2017: 901). Despite the selective and transient nature of social media events, it will be maintained that social media platforms are accessible, creative, expressive, and participatory (Kangere et al. 2017: 901), and so they can breathe new life into the topic of sexism in healthcare. What follows are two case studies of specific on-line events: a Facebook incident to illustrate how social media can breed misogyny and a hashtag movement which challenges the sexism endemic within healthcare.

Facebook, Cyber VAWG, and Misogyny

There are approximately 4.2 billion internet users in the world (55% of the world's population) (Internet World Stats 2018), and Facebook is the world's most popular social networking site with 2 billion users (Statista 2018b) (Statista.com 2018b). Facebook is also popular among healthcare students. For instance in their survey of 682 healthcare professional students, White, Kirwan, Lai, Walton, and Ross (2013) found that 93% of respondents used Facebook, with the majority (76%) checking their account at least twice a day, and 39% checking it at least five times a day. The first Australian survey of healthcare professional students also found high social media usage, especially with Facebook (Usher, Woods, Glass, Wilson, Mayner, Jackson et al. 2014: 99). The ubiquity of Facebook has also resulted in this social media platform becoming implicated in the unprofessional behaviour of healthcare students. Studies have found that healthcare students have used Facebook to breach patient confidentiality in various postings (Thompson 2010), engage in online relationships with patients (Nyangeni, du Rand, and van Rooyen 2015), and write disrespectful comments about colleagues and employers (Chretien, Greysen, Chretien, and Kind 2009; Hall, Hanna, and Huey 2013). Neville (2017b) found that most of the Fitness to Practise cases investigated and upheld by the General Dental Council over a three-year period in the UK involved Facebook posts. As a result, Facebook, as a participatory social networking site, provides an opportunity to explore how the norms, values, and behaviours of professionalism are interpreted and constructed by today's young healthcare professionals.

A recent case in Canada demonstrates the role that Facebook can play in revealing and problematising implicit sexist assumptions about gender in professional education programmes. In 2014, the School of Dentistry at Dalhousie University in Halifax, Canada, became embroiled in a social media scandal concerning the Facebook activities of its Year 4 male students. Thirteen of the 26 male dental students created a 'Class of DDS 2015 Gentlemen' Facebook group. There, male students voted on which female classmates they

would like to have ‘hate sex’ with and joked about using chloroform on women. In another post, a woman was shown in a bikini with the caption, ‘Bang until stress is relieved or unconscious’(Hunter 2015). The female students (21 in total) lodged a formal complaint about the derogatory remarks posted online about them, and a full departmental and university investigation was launched (Hunter 2015). The 13 men in question were removed from the programme as the academic investigation was undertaken. The investigating committee decided that the students in question should undergo a restorative justice programme and write and read a full letter of apology to their classmates, before they could rejoin the year (Hunter 2015).

A feminist analysis of this social media event highlights three issues for discussion. At its most obvious, we can interpret this event as further evidence of how ‘men have turned on women online’ (Jane 2017: 1) using ‘the rhetoric of sexualised, gendered violence’ (Jane 2017: 2) in their posts. Sadly, ‘gendered cyberhate’ (Jane 2017: 5) has been part of the internet since its inception and is on the increase. In 2015, the UN created the category of ‘cyber VAWG’ defined as ‘cyber violence against women and girls’ to highlight this as an issue, which though it starts online has offline implications (UN Broadband Commission 2015: 1). The UN outlines six categories of cyber VAWG: hacking, impersonation, surveillance/tracking, harassment/spamming, recruitment, and malicious distribution (UN Broadband Commission: 22).

The ‘gendered hate speech’ (Jane 2017: 2) that the male dentistry students used is also worrying as it calls into question the inclusivity of professional programmes. The cohort’s brutish assertion of hegemonic masculinity can be interpreted as a male backlash (Faludi 1991) against the feminisation of dentistry and a reassertion of male dominance in response to their experience of being in the minority. Such gendered power plays are interesting to observe because of the gender–power nexus that operates within medicine, and healthcare

more generally. Hierarchy in healthcare is multifaceted, operating vertically and horizontally 'by both their disciplines and levels of authority' (Hughes and Salas 2013: 529)(Liberatore and Nydick 2008, cited in Hughes and Salas 2013: 529). Healthcare students, therefore, are located on the lowest rank of the hierarchy, and experience the most acute of these power asymmetries. Numerous studies have identified the various ways in which 'hierarchically-laden behaviours' and their emotional and performance-based outcomes define medical culture (Braithwaite, Clay-Williams, Vecellio, Marks, Hooper, T, Westbrook et al. 2016: 8). Intimidation, humiliation, and harassment are often cited as the common pedagogic tools used by faculty in most undergraduate and specialist training medical programmes (e.g. Lempp 2009; Crowe, Clarke and Brugha 2017: 70-71) (eg, Lempp 2009; Richardson et al. 1997; Wilkinson, 2006; Frank et al. 2006, cited in Crowe, Clarke, and Brugha 2017: 70–71). Sexual harassment is part of this continuum (Mathews and Bismark 2015: 1889). (Komaromy et al. 1993; White 2000; Larsson, Hensing, and Allbeck 2003; Cook et al. 1996, cited in Mathews and Bismark 2015: 189). As a result, we can interpret this social media event as evidence of the gender conflict and power imbalances that permeate healthcare student culture, especially in professional programmes.

Last, this story can be interpreted as evidence of a success for feminist activism: taking this negative experience and turning it into a moment of activism and gender awareness building. While the offending students were sanctioned by the institution, it is important to note that some of the female students were upset that a restorative justice approach was taken, interpreting it as a 'softer' line of sanctioning than could have been adopted by the institution (Hunter 2015). The Facebook posts contained threats of sexual violence—can a verbally delivered apology really make amends for such gendered hate speeches against classmates? There are echoes of the bourgeois assumptions of professionalism again here, where an apology seems like the 'gentlemanly' thing to do to

restore the ‘honour’ and ‘reputation’ of the ‘delicate’ and ‘offended’ female classmates. By remediating the issue in this way, it reframes the problem of misogyny as something that is cultural, and therefore attributable to certain rogue individuals, rather than something that is structural and systemic in nature. As a result, there is a real risk that the consciousness-raising potential of this awful event may be lost out of a desire to protect the institution. This case then reminds us that cyber VAWG can occur in any workplace and educational setting, and that institutions need to recognise it as a new category of harmful workplace experience that will need to be monitored and checked for in relation to school policies on professionalism and acceptable behaviours (see Sojo, Wood, and Genat 2016).

#Hashtagging Patriarchy

The above case study illustrates how social media can act as an echo chamber for online misogyny. However, we have already remarked that social media can also act as a launchpad for calling out gender inequalities and ‘shouting back’ against patriarchy. While the Dalhousie University Facebook incident presents gender as a socio-cultural construction, open to contrasting interpretations, the hashtag movement #ILookLikeASurgeon presents gender as a structural reality, with lifeworld implications for women working in medicine. The hashtag movement #ILookLikeASurgeon will also be used to demonstrate the potential of social media to raise gender awareness in the medical profession.

The hashtag movement #ILookLikeASurgeon is ‘an online campaign celebrating women in surgery’ (Logghe, Jones, McCoubrey, and Fitzgerald 2017). It has currently inspired 150,000 tweets, 35,000 users, and up to 1 billion impressions online (Logghe et al. 2017). Its aim is to highlight the barriers women face in surgery, and to challenge the gendered construction of surgeons. It calls for a more inclusive model of surgery (Logghe et al. 2017). As Logghe et al. (2017) have mentioned ‘the hashtag underlines the need to create

a new surgeon ideal'. It hopes to change popular perceptions about what a surgeon is, increase the number of women working in surgery, and to have a positive impact on patient outcomes (Logghe et al. 2017). This hashtag movement has garnered much attention within medicine in the US and internationally. For instance, one spinoff has been the 'Women in Surgery Africa' Twitter account group (Logghe et al 2017) (Logghe 2017). The hashtag movement was also mentioned by Caprice Greenberg in her 2017 presidential address to the Association for Academic Surgeons in the US (Logghe et al. 2017).

The creation of the hashtag #ILookLikeASurgeon was directly influenced by another hashtag movement, #iLooklikeAnEngineer. This hashtag was created by software engineer, Isis Anchalee, in response to the negative feedback she received from being featured in an advertising campaign for her employer (UNC Healthcare and UNC School of Medicine 2015). Most of the negative comments challenged the veracity of the campaign, stating that they did not believe she was a software engineer working at that company (UNC Healthcare and UNC School of Medicine 2015). This story was featured in *The New York Times* on 5 August 2015. Heather Logghe, a surgical trainee, read this story and after a conversation with female colleague, Dr Sara Scarlet, decided to write a tweet in response (UNC Healthcare and UNC School of Medicine 2015): 'Hashtag Aims to Break Gender Stereotypes in engineering - Is 'Ilooklikeasurgeon next?' In her tweet she posted a photograph of herself and her young daughter. She also wrote a blog post entitled, '#ILookLikeASurgeon Tweet it. Own it. Be the role model You always wanted but never had'(Logghe 2015). (Logghe 2015 quoted in Hughes 2015). This hashtag went viral after a few days and the original blog was read 7000 times, culminating in several guest female bloggers adding their voices to this issue (UNC Healthcare and UNC School of Medicine 2015). The story was picked up by various US and internal news outlets, including the *Today Show* and *BBC Trending* (UNC Healthcare and UNC School of Medicine 2015).

The hashtag #ILookLikeASurgeon was resurrected again in April 2017. On 4 April 2017, the cover of *The New Yorker* was designed by Malika Favre. The art work presented the perspective of a patient on a surgical table, looking up at four gowned and masked faces overhead. The purpose of the cover was, according to the artist, 'to capture a patient's feeling of vulnerability' (Savedge 2017). However, when the magazine cover was seen by Dr Pitt, who was on her way to the American Association of Endocrine Surgeons' conference, she tweeted the magazine cover to some of her female colleagues using the hashtag #ILookLikeASurgeon, challenging all recipients to reproduce this image with their female colleagues (Hughes 2015). This challenge went viral, and was taken up by female surgeons in Mexico, Brazil, Saudi Arabia, Istanbul, and Ireland (Savedge 2017). Overall, it resulted in 30,000 tweets using the hashtag (URMC 2017).

What is the significance of this hashtag movement? First, it reminds us of the short but frenzied social life of a hashtag movement, how one tweet can spark a viral sensation. According to Symplur (2015 cited in Hughes 2015), the hashtag generated 128 million impressions, 40,000 individual tweets, and 7900 participants in its initial months. It has been retweeted in 75 countries and in 20 languages (Hughes 2015). Nevertheless, from its inception, this hashtag aligned itself with a feminist agenda. According to its originator, Dr Logghe, its aim was to be affirmative and political: 'I like the hashtag in the first person. As woman surgeons, whether we are in our first year of training or an emeritus professor, it's most important that we ourselves believe we "look" like surgeons. Because we do.' (Logghe 2015 quoted in Hughes 2015). The online growth of the hashtag has a consciousness-raising effect, challenging gendered perceptions and highlighting the structural inequalities that persist within surgery. #ILookLikeASurgeon reminds us that women are seriously underrepresented in surgery. In the US, only 19 per cent of surgeons are female (American Medical Association cited in Savedge 2017). In the UK, the figure is closer to 10 per cent

(Garner and Bowbrick 2015). The reasons for the low representation of women in surgery reflect the gendered nature and macho culture of surgery (Peters and Ryan 2014), as well as the incompatibility of the work schedule with family life (e.g. Sund 2017). However, what can a hashtag do to effect change in these structural and cultural factors?

An important issue in adopting a feminist approach to this investigation concerns how and in what ways can we translate these observations into action and change for women and men working in healthcare (Kangere et al. 2017: 902). One of the key aspects of feminist scholarship in social media is that online activism needs to be matched by offline organisation and activism if it is to gain any ongoing improvements. In the above example we noted that the hashtag movement generally inspired individual responses from female surgeons, staging and posting photos rather than collective responses. While it also inspired the creation of a 'Women in Surgery' Twitter group in Africa, there does not appear to be much offline activism. This is not always the outcome for hashtag movements. For instance, the #LikeALadyDoc hashtag movement in the UK emerged, in January 2016, in response to a sexist newspaper article written by Nigel Lawson, in *The Sunday Times* (2016). Entitled, 'The one sex change on the NHS that nobody has been talking about' (Lawson 2016), the article critiqued the feminisation of medicine and openly attributed the growing number of female medics and their over-representation in part-time contracts as one of the main failings of the National Health Service. Understandably, there was swift reaction to this article online, culminating in the establishment of the #LikeALadyDoc hashtag, used by women medics as they posted their reactions to the article. Posts included recalling pioneering women in medicine, documenting their love of their job, as well as the challenge of long working hours alongside family responsibilities. Interestingly, Roshana Mehdian, one of the original contributors to the hashtag, created another hashtag, #PinkWednesday, inviting NHS employees to wear pink to work in solidarity with their female colleagues and to post their

photos online on 20 January 2016. #PinkWednesday was a success, attracting support from NHS staff and non-NHS staff in solidarity with women in healthcare, and garnered media attention as far away as Australia.

This is one example of where a hashtag movement can result in offline activism. However, more needs to be done to sustain public and sectoral interest in gender inequality and workplace sexism. Digital feminism proposes that a hashtag movement needs to be supported by an offline network or group, who will continue to work and garner attention on this issue (Kangere et al. 2017; Korn and Kneese 2015). Ideally, an offline interest group needs to be established, one that will be concerned with the issue of gender inequality in healthcare and its divisive effects. The remit of this group or groups could be twofold—to support and encourage further research on the gender inequalities within healthcare, as well as to lobby professional bodies and regulators on gender inequality as a critical issue for healthcare in the twenty-first century. This important upstream policy work could also be supported by further research by digital feminists studying the online activism of female medics. In this way, digital feminism could help advance its activist agenda, as well as the recognition of the positive impact of social media as a means of sharing opinions and creating debate and discussion.

Concluding Comments

These cases are a timely reminder of the 'pervasive, structural nature' of sexism and gender inequality in healthcare by 'linking the specific local case to larger narratives of inequality' (Baer 2016: 18). Approaching social media as a means of exploring and making visible the endemic nature of gender inequality and discrimination in healthcare gives us an opportunity to present an alternative viewpoint on social media that is commonly promoted in the literature, namely that it is a vehicle for unprofessionalism. Social media can capture and

amplify these sexist undertones and bring them to public light. The outcomes will be to raise awareness of the inherent sexism in healthcare, especially when we consider how ‘gender neutral’ the rhetoric of feminisation is: There is a naïve assumption that feminisation has been accompanied by a cultural shift. While the numbers of women in healthcare professions are increasing, there is still much to be done regarding the values, norms, and beliefs within healthcare, to move away from the androcentric model of professionalism. Calls for such a paradigm change will benefit both women and men healthcare workers, as Millennials of all genders are openly concerned with flexibility and maintaining a healthy work–life balance (Ernst & Young 2016:8). This chapter recommends that the healthcare establishment pays more attention to the online activism of healthcare professionals and recognise the need for the institution to address its implicit, unconscious or otherwise, gender biases. As the number of women continues to increase in healthcare, and in light of Millennial workers’ expectation of flexibility, we need to ensure that healthcare is a progressive and inclusive work environment for all.

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